CON Task Force Issue Brief

Licensure of Total Acute Care Hospital Beds and Projecting MSGA Bed Need

Statement of the Issue

If the Certificate of Need (CON) program continues to regulate the supply of acute care hospital beds and the State Health Plan continues to include a projection of bed need for MSGA beds used in CON regulation, should that bed need projection assume that hospitals need MSGA bed capacity equal to 140% of projected average daily census of MSGA patients?

Should the CON program regulate the supply of acute care hospital beds?

Summary of Public Comments

The Task Force received comments from seven organizations and one individual consultant which, while expressed in different ways, essentially embody a single recommendation. That recommendation is to change the average annual occupancy rate scale currently used in the State Health Plan to forecast the need for medical/surgical/gynecology/addictions (MSGA) beds to a single average annual occupancy rate standard of 71.4%. This latter standard (often referred to as the "140% rule" – 100/140 = 71.4%) is used by the Department of Health and Mental Hygiene to establish the total number of licensed acute care beds in hospitals by applying it to historically reported total acute care average daily census. This comment was received from:

Carolyn W. Core, Vice President, Corporate Services, **Civista Health**
Brian A. Gragnolati, President and CEO, **Suburban Hospital**
Donna L. Jacobs, Senior Vice President, Government and Regulatory Affairs, **University of Maryland Medical System**
The Maryland Hospital Association
Thomas R. Mullen, President and CEO, **Mercy Health Services**
William G. "Bill" Robertson, President and CEO, **Adventist HealthCare**
John M. Sernulka, President and CEO, **Carroll Hospital Center**
Andrew L. Solberg of **A.L.S. Healthcare Consultant Services**

The Task Force received comments from **Hal Cohen**, on behalf of himself and **CareFirst Blue Cross Blue Shield** which recommends that MHCC seek elimination of the 140% rule for licensing total acute care hospital bed capacity from state law. Mr. Cohen states that the rule served its purpose for establishment by eliminating paper beds but now it sometimes creates paper beds. He states that it is much too low an occupancy rate for need purposes and further recommends that the

State Health Plan's current occupancy rate scale for projecting MSGA bed need is too low and should be revised upward for larger hospitals.

One organization and one individual recommended that increases in bed capacity by existing hospitals should not be regulated under the CON program in all circumstances and both referenced the "140%" rule used in licensure of acute care hospital beds as a basis for this change in the scope of the program. Warren A. Greene, President and CEO of **LifeBridge Health**, recommends that a CON should not be required to increase hospital bed capacity so long as the hospital pledges not to seek a rate increase to cover project costs. He states there is no incentive to build unnecessary beds and cites the "linkage" between licensed capacity and occupancy as recognition by the General Assembly that hospitals need to be able to increase their capacity to meet community needs. **Barry F. Rosen** of Gordon, Feinblatt, Rothman, Hoffberger & Hollander, states that, "The CON requirements for changes in bed capacity need to be reevaluated to recognize that Maryland now licenses beds based on a percentage of occupancy," noting that, "Increases in bed capacity do not automatically enable a hospital to start filling those beds."

Background

Maryland's hospital licensure law was amended, effective in 2000, to peg maximum licensed acute care bed capacity to the average daily census of acute care patients reported by hospitals. On July 1 of each year, hospital licenses are revised to reflect that the hospital is licensed (and, thus, may legally operate) a total number of acute care beds equal to 140% of the average daily census of acute care patients reported by that hospital for the twelve month period ending on March 31 of that same year The CON law was also amended to allow hospitals to construct acute care bed capacity equal to their current licensed capacity without reference to any need standards of the State Health Plan. This law had the effect of eliminating over 2,700 beds from hospital licenses when it went into effect. Currently, Maryland hospitals report that, in the aggregate, they have physical capacity for 967 more acute care beds than are licensed. Twelve of the state's 47 hospitals (26%) report having less physical capacity for acute care beds than is currently licensed. (See attached Appendix A.)

MHCC projects the need for MSGA beds and uses this bed need projection in evaluating proposals to establish new acute care hospitals, replace existing hospitals, or expand the MSGA bed capacity of existing hospitals. It uses an occupancy rate scale in projecting the need for beds based on:

- An assumption that as the average daily census of MSGA patients increases, hospitals can manage patient census at a higher level of average annual occupancy; and

- A policy that a hospital should operate at the highest level of average annual occupancy, given its level of patient census, which allows it to accommodate emergent and urgent needs for admission immediately, with only rare exceptions, and to accommodate less urgent and more elective needs for admission within a reasonable period of time.

The current MSGA average annual bed occupancy rate scale was adopted in 2004 and is lower than the scale previously used in the State Health Plan to account for the higher level of bed turnover which occurs as average length of stay declines. The current scale, the previous scale (in parentheses), and the distribution of Maryland's 47 acute care hospitals on this scale is shown on the following page.

Projected Average Daily Census	Average Annual Occupancy Rate	Number of Hospitals Falling within the Standard
0-49 patients	70% (75%)	8
50-99 patients	75% (80%)	11
100-299 (499) patients	80% (85%)	26
300+ (500+) patients	83% (87%)	2
	79% weighted average	47

Use of a 71.4% average annual occupancy rate scale for all Maryland acute care hospitals in bed need projection would result in large differences in the potential number of additional MSGA beds that could be approved. MHCC's current MSGA bed need forecast, when compared with currently designated licensed MSGA beds, identifies a potential for 398 to 777 additional beds needed by 2010. If this bed need projection had been developed using an identical forecast of MSGA patient days in 2010 but with a 71.4% occupancy standard applied to each jurisdiction, the identified potential for additional beds would be 873 to 1,775. With hospital construction costs of $750,000 to $1 million per bed, this would represent the potential for nearly $1 billion in additional capital spending for bed capacity.

Options

Eliminate the 140% Rule for Licensing Beds

This option is supported by the view that the 140% rule was established by the General Assembly as a means for reducing the number of licensed hospital beds in Maryland after years of declining patient census. Given that patient census has stabilized or is rising in most areas of the state since 1998, its primary purpose is no longer valid. Its conflict with the State Health Plan is created by rising patient census and the related need to build additional bed capacity as a response to that increasing patient census.

Eliminating the rule would reestablish hospital licensure in Maryland to the process in place for most of its history and the process used in every other state – hospitals would be licensed for the number of beds that they can physically accommodate. To be effective, DHMH would need to accurately establish the physical bed capacity of hospitals and both DHMH and hospitals would need to collaborate effectively in tracking changes in that physical capacity over time, as hospital reconfigure and redevelop their campuses, in order for hospital licensure to accurately reflect actual bed capacity.

Without changes in CON law, this option would eliminate the flexibility that hospitals have now to put into service additional bed increments as their licenses are renewed with higher number of beds. Since most hospitals currently report having physical bed capacity that is greater than licensed capacity, this is an option that can theoretically be utilized by hospitals at this time. However, the flexibility afforded by this rule will largely be eliminated if patient census continues to increase and fewer hospitals have existing physical capacity to bring back in service or capacity that is appropriate and functional to bring into service, a problem already encountered by several hospitals seeking CONs for capital projects. Because the rule is based on historic census, it often will not provide hospitals with the automatic ability to expand bed capacity in an economically feasible manner.

Adopt the 71.4% Average Annual Occupancy Rate Assumption Implied by the 140% Rule as the Occupancy Rate Standard Used in Bed Need Projection

This option would allow hospitals seeking to expand MSGA bed capacity to construct greater numbers of beds (See Appendix B and C.) and reduce the likelihood that hospitals would be legally able to construct additional bed increments, because of increases in their licensed bed capacity, that would not be approvable under the State Health Plan, because they would not be identified as needed. It would not work in this way as a standard for pediatric beds, given that the State Health Plan uses an average annual occupancy rate of 50% for most jurisdictions now, given the very small size of most hospital's pediatric patient census. The State Health Plan does not include a bed need projection methodology for obstetric beds, although the demand functions that have historically been used to assess OB bed need would assume a lower average annual occupancy rate for small to medium-sized obstetric patient censuses than 71.4%. The State Health Plan uses an acute psychiatric bed occupancy standard of 80%, which should be reconsidered given the large reduction in average length of stay for this service that has occurred in the last two decades.

This option would run counter to long-established notions with respect to achievable bed occupancy rates for varying levels of patient census. Average daily MSGA patient census in Maryland hospitals ranged from less than 5 patients to more than 500 patients in CY2004. It would establish an occupancy rate expectation for most Maryland hospitals that is lower than the evidence would suggest is possible for these hospitals. Developing production capacity that exceeds demand for the service being produced unnecessarily increases costs, under conventional microeconomic assumptions. Additionally, Maryland hospitals have begun and made major progress in a transformation of their inpatient nursing units to all private room accommodations. The elimination or massive reduction in semi-private rooms will allow hospitals to operate at higher average levels of bed occupancy than in the past.

Eliminate CON Regulation of Expansions of Hospital Bed Capacity

This option assumes that dynamic licensure that tracks changes in patient census eliminates the need for controlling the supply of beds constructed by hospitals. If hospitals err in building too many beds, they will be unable to license these beds and, so long as they are not given rate adjustments to help them pay for their mistakes, the public will, in theory, not be negatively affected by overbuilding.

This option would seem to have significant potential problems. First, as noted above, it sets the bar for "excess bed" construction fairly low for most Maryland hospitals, under the current licensure standard of 140% of patient census. It also assumes that Maryland will be successful in maintaining the discipline required to deny any adjustment in rates for hospitals that overbuild, which may be difficult if the hospital suffers serious financial consequences. Finally, it would tend to eliminate or greatly reduce the potential for new hospitals to enter the Maryland market. If CON would still be required to establish a new hospital, as the advocates for this option propose, such potential applicants would seem to be at an insurmountable disadvantage. As with ambulatory surgery, Maryland would be evaluating the need for a project, without having any effective control on the supply of the service capacity that project would be proposing.

Adopt the Occupancy Rate Scale Used in the State Health Plan as the Implied Average Annual Occupancy Rate in Hospital Licensure

This option is a way to bring more consistency between the licensure law and bed need projection standards of the State Health Plan by reforming licensure law to be more consistent with the SHP – the opposite of the second option outlined above. This would involve keeping dynamic licensure for total acute care beds that tracked with changes in patient census, but using a scale of occupancy rates in the annual revision of licenses which would achieve rough consistency with the State Health Plan's MSGA occupancy rate scale, given the range of hospital sizes and patient service mixes found in Maryland.

An example of this approach is outlined below:

- For hospitals with total acute care patient census of 39 or less, total acute care licensure would be established as 155% of patient census (an average annual occupancy rate of 65%);

- Total acute care patient census of 40-99 – licensure established as 145% of census (69%);

- Total acute care patient census of 100-149 – licensure established as 135% of census (74%);

- Total acute care patient census of 150-299 – licensure established as 130% of census (77%); and

- Total acute care patient census of 300+ – licensure established as 125% of census (80%);

This option would preserve the flexibility of dynamic licensure for incremental changes in bed capacity but would eliminate any significant inconsistencies between licensure and bed need projection policies, as currently established in the State Health Plan.

APPENDIX A: Physical and Licensed Acute Care Bed Capacity - Maryland General Hospitals

Hospital Name	Licensed Beds FY 2006	Total Available Physical Capacity	Difference
Anne Arundel Medical Center	265	282	(17)
Atlantic General Hospital	40	62	(22)
Baltimore Washington Medical Center*	278	304	(26)
Bon Secours Baltimore Health System	142	157	(15)
Calvert Memorial Hospital	105	111	(6)
Carroll Hospital Center	199	218	(19)
Chester River Hospital Center	57	55	2
Civista Medical Center	117	115	2
Doctors Community Hospital	181	202	(21)
Dorchester General Hospital	58	80	(22)
Edward W. McCready Memorial Hospital	8	26	(18)
Fort Washington Hospital	41	37	4
Franklin Square Hospital	343	329	14
Frederick Memorial Hospital	232	255	(23)
Garrett County Memorial Hospital	33	50	(17)
Good Samaritan Hospital of Maryland	279	193	86
Greater Baltimore Medical Center	287	342	(55)
Harbor Hospital	182	196	(14)
Harford Memorial Hospital	91	109	(18)
Holy Cross Hospital of Silver Spring	365	364	1
Howard County General Hospital	204	186	18
James Lawrence Kernan Hospital	10	25	(15)
Johns Hopkins Bayview Medical Center	316	313	3
Johns Hopkins Hospital	956	989	(33)
Laurel Regional Hospital	108	185	(77)
Maryland General Hospital	196	250	(54)
Memorial Hospital & Medical Center of Cumberland	124	272	(148)
Memorial Hospital at Easton Maryland	129	150	(21)
Mercy Medical Center	228	228	-
Montgomery General Hospital	144	207	(63)
Northwest Hospital Center	209	190	19
Peninsula Regional Medical Center	360	369	(9)
Prince George's Hospital Center**	269	340	(71)
Sacred Heart Hospital	144	267	(123)
Shady Grove Adventist Hospital	269	238	31
Sinai Hospital of Baltimore	392	356	36
Southern Maryland Hospital Center	246	340	(94)
St. Agnes Healthcare	308	385	(77)
St. Joseph Medical Center	342	354	(12)
St. Mary's Hospital of St. Mary's County	88	115	(27)
Suburban Hospital	228	232	(4)
Union Hospital of Cecil County	111	122	(11)
Union Memorial Hospital	287	329	(42)
University of Maryland Medical System	665	617	48
Upper Chesapeake Medical Center	149	143	6
Washington Adventist Hospital	292	304	(12)
Washington County Health System	246	297	(51)
TOTAL	**10,323**	**11,290**	**(967)**

Source: OHCQ and MHCC Application for Annual Licensed Bed Designation, FY2006 (self-reported data)

APPENDIX B

TARGET YEAR 2010 PROJECTED MSGA NET BED NEED/EXCESS USING THE CURRENT STATE HEALTH PLAN OCCUPANCY RATE SCALE

Jurisdiction	Physical Acute Care Bed Capacity in Excess of Total Licensed Acute Care Bed Capacity	Licensed MSGA Beds FY2006	Gross Bed Need		Net Bed Need/Excess (Net of Licensed Capacity)	
			Low Forecast	High Forecast	Low Forecast	High Forecast
Allegany	271	236	206	245	(30)	9
Frederick	23	181	198	217	17	36
Garrett	17	27	42	45	15	18
Washington	51	203	182	201	(21)	(2)
Western MD	*362*	*647*	*628*	*708*	*(19)*	*61*
Montgomery	47	965	968	1,081	3	116
Calvert	6	78	94	104	16	26
Charles	(2)	97	110	121	13	24
Prince George's	277	688	720	808	32	120
St. Mary's	27	58	87	95	29	37
Southern MD	*308*	*921*	*1,011*	*1,128*	*90*	*207*
Anne Arundel	43	457	550	600	93	143
Baltimore City	77	3,217	2,803	3,102	(414)	(115)
Baltimore County	34	983	982	1,087	(1)	104
Carroll	19	152	176	189	24	37
Harford	12	206	247	271	41	65
Howard	(18)	147	165	181	18	34
Central MD	*167*	*5,162*	*4,923*	*5,430*	*(239)*	*268*
Cecil	11	95	114	122	19	27
Dorchester	22	40	58	64	18	24
Kent	(2)	49	53	58	4	9
Somerset	18	8	19	21	11	13
Talbot	21	102	130	132	28	30
Wicomico	9	320	270	298	(50)	(22)
Worcester	22	40	57	61	17	21
Eastern Shore	*101*	*654*	*701*	*756*	*47*	*102*
MARYLAND	985	8,349	8,231	9,103	(28)	754

BECAUSE BED NEED IS EVALUATED AT THE JURISDICTIONAL LEVEL, THE IMPLICATION OF THIS BED NEED PROJECTION IS THAT ADDITIONAL MSGA BEDS NET OF LICENSED BEDS ARE IDENTIFIED AS NEEDED IN 17 JURISDICTIONS AT THE LOW RANGE TOTALING 398 BEDS.

ADDITIONAL MSGA BEDS NET OF LICENSED BEDS ARE IDENTIFIED AS NEED IN 19 JURISDICTIONS AT THE HIGH RANGE TOTALING 777 BEDS.

APPENDIX C

TARGET YEAR 2010 PROJECTED MSGA NET BED NEED/EXCESS USING THE RECOMMENDED OCCUPANCY RATE STANDARD OF 71.4%

Jurisdiction	Physical Acute Care Bed Capacity in Excess of Total Licensed Acute Care Bed Capacity	Licensed MSGA Beds FY2006	Gross Bed Need		Net Bed Need/Excess (Net of Licensed Capacity)	
			Low Forecast	High Forecast	Low Forecast	High Forecast
Allegany	271	236	216	257	(20)	21
Frederick	23	181	222	243	41	62
Garrett	17	27	41	44	14	17
Washington	51	203	204	225	1	22
Western MD	*362*	*647*	*683*	*769*	*36*	*122*
Montgomery	47	965	1,071	1,196	106	231
Calvert	6	78	99	109	21	31
Charles	(2)	97	116	127	19	30
Prince George's	277	688	796	894	108	206
St. Mary's	27	58	91	100	33	42
Southern MD	*308*	*921*	*1,102*	*1,230*	*181*	*309*
Anne Arundel	43	457	616	672	159	215
Baltimore City	77	3,217	3,179	3,518	(38)	301
Baltimore County	34	983	1,100	1,217	117	234
Carroll	19	152	197	212	45	60
Harford	12	206	270	296	64	90
Howard	(18)	147	185	203	38	56
Central MD	*167*	*5,162*	*5,547*	*6,118*	*385*	*956*
Cecil	11	95	120	128	25	33
Dorchester	22	40	57	63	17	23
Kent	(2)	49	52	57	3	8
Somerset	18	8	19	21	11	13
Talbot	21	102	137	148	35	46
Wicomico	9	320	302	334	(18)	14
Worcester	22	40	56	60	16	20
Eastern Shore	*101*	*654*	*743*	*811*	*89*	*157*
MARYLAND	985	8,349	9,146	10,124	797	1,775

BECAUSE BED NEED IS EVALUATED AT THE JURISDICTIONAL LEVEL, THE IMPLICATION OF THIS BED NEED PROJECTION IS THAT ADDITIONAL MSGA BEDS NET OF LICENSED BEDS ARE IDENTIFIED AS NEEDED IN 19 JURISDICTIONS AT THE LOW RANGE TOTALING 873 BEDS.

ADDITIONAL MSGA BEDS NET OF LICENSED BEDS ARE IDENTIFIED AS NEEDED IN ALL 22 JURISDICTIONS AT THE HIGH RANGE TOTALING 1,775 BEDS.